Afterword

By now, readers will have recognized that it is a mistake to take the title of Jon Shane's "Learning From Error in Policing: A Case Study in Organizational Accident Theory" too literally. This monograph delivers much more than the modest recounting of events that its title implies. Among its many virtues is the precision with which it mobilizes a mode of analysis that is currently unfamiliar to the criminal justice world but that both street-level practitioners and academic researchers will recognize immediately as one that blazes a promising new road forward.

The criminal justice system has coasted for a long time on the illusion of practical infallibility. Practitioners knew that this was a fiction, of course, but on balance, it seemed to be a fiction worth sustaining. Are there people in prison who said they are innocent? The response, "They all *say* they are innocent" was good enough to dispose of that worry—until the DNA exoneration cases began to roll in. Now, in the aftermath of the DNA cases, the public knows that criminal justice is no more immune to human error than is medicine, aviation, or industry, and the fundamental legitimacy of the system—its ability to generate public trust in the law—will depend to a high degree on how practitioners and policy-makers confront their own errors.

One way to react to this situation—the prevalent way—is to convene a blue ribbon Innocence Commission or Wrongful Conviction Task force. These groups of dignitaries distill "causes" from the exoneration lists, rank those causes by the frequency of their recurrence, and develop a reform agenda. In these schemes, cases are reduced to "an eyewitness case" or "a false confession case" or "a forensic error case" and the archetypes generated in this way are subjected to statistical analysis. Often "best practices" are identified, and sometimes those are embedded in rules, legislation, or checklists.

This strategy undoubtedly improves the odds. But no checklist can cover every eventuality, and from the moment it is instituted every new checklist or set of best practices is under immediate and aggressive assault from its environment—from economic pressures, rising crime rates, tightening budgets, and pressing clearance rate demands.

Shane is willing to accept the reality that there is no single cause for most mistakes, no "silver bullet" solution for most problems, and no permanent, stable

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"solution" for anything. His monograph shows how important it is to admit that nothing is simple: that every error is embedded in a complex event involving multiple actors, who make small choices that interact with each other and with latent system weaknesses.

Unexpectedly, this insight turns out to be liberating. Once we face the complexities of adverse events we can see that our challenge is not the ultimately hopeless one of protecting a presumptively reliable system from careless or incompetent humans; rather, it is to invigorate and continually improve system reliability by taking account of the inevitability of human error.

In Shane's hands, an error becomes not something to sweep under the rug, but a "sentinel event," a valuable lens through which we can learn important lessons about preventing future mistakes. We can give the good guys in the system something to do besides trying to catch and exorcise the lazy, incompetent, corrupt, bad guys.

Shane shows how even an apparently routine street show-up, can yield important lessons when treated as an "organizational accident". To do this, he clears away a substantial pile of dead wood. He concentrates on professionalism and reliability as criteria; not on the criterion of legality that the Warren Court's constitutional decisions have imposed on show-up and street stop performance. He assumes that no single-cause, "bad apple" explanation will explain everything. He recognizes that the fact that a street-level investigator or mid-level manager zigged when he should have zagged is often apparent only in hindsight, and that the real question if we want to prevent recurrences is why the wrong decision looked like the *right* decision at the time. He gives one small, retail policing event the sustained analytic attention it deserves, and by doing this he shows that this mundane "near miss" is important *because* of its mundane, retail nature—because of the number of times its scenario will be replayed if we don't intervene.

On the surface there is an element here of taking policing away from the lawyers and giving it back to the police. There's value in that, but there is more here than a call for reasserting police responsibility for police work. This study shows how the best of social science (here, the science of eyewitness memory), the best of process analysis and expertise, and most perceptive understanding of the gritty, thickly-textured nature of sharp-end decision-making can be brought into harness together. A reader can learn more about how and why an eyewitness case can go wrong from this monograph than from any other single source. And a reader can learn how the *next* eyewitness case will go wrong unless the lessons of this sentinel event are learned.

But those specific insights into eyewitness cases are not the most important aspect of this work. Shane's monograph also points to the possibility of a common ground on which all of the criminal system's stakeholders could—like their precursors in aviation, industry and medicine—meet, apply his "organizational accident" approach, and begin the work of continually improving system reliability.

I expect that readers will finish this "case history" eager to analyze the history of another case. Then another. And share the results. This is an important step—no make that leap—in the right direction.

—James Doyle

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